Xyrem (sodium oxybate)
Xywav (calcium, magnesium, potassium, and sodium oxybates)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval: *(all criteria must be met)* ***Max Dose 9gm per day***

- ❑ Patient is 7 years or older.
- ❑ Diagnosis of ❑ Cataplexy associated with narcolepsy **OR** ❑ Excessive daytime sleepiness with narcolepsy
- ❑ Patient is enrolled in Xywav and Xyrem REMS Program.
- ❑ Prescribed by or in consultation with a physician that is board certified in sleep medicine.
- ❑ Prescriber is enrolled in Xywav and Xyrem REMS Program and attests to complying with safety requirements.
- ❑ Ruled out concomitant use of sedative-hypnotics, alcohol, or CNS depressants. Chart Note Page #: _____
- ❑ Insufficient response to adequately dosed and appropriate length of treatment with modafinil and/or armodafinil. (concomitant use is allowed)

  Medication(s): _____ Chart Note Page #: _____

  Dates of therapy: _____ Details of Failure: _____

Additional Criteria for Xywav:

- ❑ Clinically significant requirement for sodium restriction. (Describe and include relevant chart notes)

  Description: _____ Chart Note Page #: _____

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to three (3) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date